STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155243	A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANS CARE AND REHAB-GREATER LAFAYETTE	300 WINDY HILL DRIVE LAFAYETTE, IN47905

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of complaint numbers IN00093248 and IN00093415. Complaint number IN00093248; Unsubstantiated due to lack of evidence Complaint number IN00093415; Substantiated, no deficiencies related to the allegations are cited. Survey Dates: July 26, 27, 28, 29, and August 1, 2011 Facility Number: 000147 Provider Number: 155243 AIM Number: 100266900 Survey Team: Linda Campbell, RN, TC Janet Stanton, RN (July 26, 27, 28, 29, 2011) Rita Mullen, RN (July 26, 27, 28, 29, 2011) Michelle Hosteter, RN (July 26, 27, 28, 29, 2011) Heather Lay, RN (July 27, 28, 29, 2011) Census Bed Type:	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	SNF/NF: 136 Total: 136 Census Payor Type: Medicare: 29 Medicaid: 82 Other: 25 Total: 136 Sample: 24 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 8/2/11 Cathy Emswiller RN			
F0248 SS=D	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure a resident was provided ongoing activities in accordance with the resident's assessed needs for 1 of 24 residents in a sample of 24. (Resident #25). Findings include:	F0248	F 248 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #25 to be invited and encouraged to attend both group and one on one activities. Staff to	08/31/2011

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	On 7/26/11 at 9:10 A.M., during an initial tour with LPN #3, Resident #25 was identified as being in a wheelchair, having a pressure ulcer, and having a foley catheter. Interview on 7/28/11 at 8:45 A.M. with Resident #25 indicated she stayed in bed frequently and watched television. She indicated if she attended activities "they would have to get me out of bed." She indicated she would like to have more activities provided to her. Resident #25's clinical record was reviewed on 7/28/11 at 8:30 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, chronic obstructive pulmonary disease, osteoarthritis, anemia, and sacral wound. A Minimum Data Set (MDS) admission assessment dated 3/4/11 indicated the resident was moderately impaired in cognitive decision-making skills, considered going outside to fresh air when the weather was good and participating in religious services or practices somewhat important, required total two-person assistance for transfer, was non-ambulatory, and was able to use a wheelchair.		document resident's participation and/or refusal to participate. The Director of Activities to review the documentation for resident #25 weekly to ensure resident is provided with an ongoing activities program in accordance with the resident's assessed needs. Activity Assistants were re-educated on providing residents with ongoing activity programs in accordance with residents assessed needs and appropriate documentation of residents who refuse activities. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. The Activity Director will conduct an audit of residents activity participation documentation to ensure residents participation and/or refusal of activities. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The Activity Assistants were re-educated on the completion of daily documentation and completion of activities participation records. How the corrective action(s) will be monitored to ensure the deficient	

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	A "Pleasant and Meaningful Activities" form dated 3/3/11 indicated "...Enjoys now...eating out...(name of restaurant)...bible study (indicated by checkmark)...church services...Christian...watching television... (name of movie)...theater and art (indicated by checkmark)...visiting with pets (indicated by checkmark)..." A "Recreation/Leisure Patterns Summary" dated 3/3/11 indicated "...individual can choose events and leisure pursuits of interest, but requires/desires prompting to attend...individual has toured building needs assistance in locating leisure resources...preferences/strengths incorporated into the following programming:...watching TV, bingo...pet visit, coffee/donuts, nails..." An activity progress note dated 5/24/11 indicated "...Res (resident) enjoys attending some groups such as bingo, nails, and coffee/donuts. She also enjoys pet visits sometimes. Writer will continue to observe res activities pursuits and participation..." A resident care plan dated 3/7/11 and updated 7/10/11 indicated "...Resident is able to plan her own leisure time and can choose preferred activities to attend. She		practice will not recur, i.e. what quality assurance program will be put into place. Activity Director to monitor activities participation records weekly to ensure ongoing compliance. Audit findings to be reported to the Performance Improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance. Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.	

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	spends limited time out of bed and would benefit from one to one activities as needed...Approach...(1) Staff will invite resident to activities that meet her interests she might enjoy. (2) Staff will assist resident to/from activities that she wishes to attend. (3) Staff will encourage her to participate in activities. (4) She will engage resident in one to one activities as needed." Activity Logs indicated: April 2011- the resident attended 4 group activities. Documentation was lacking related to the resident being invited or refusing to attend any additional group activities. May 2011 - the resident attended 5 group activities. Documentation was lacking related to the resident being invited or refusing to attend any additional group activities. June 2011 - the resident attended 5 group activities. Documentation was lacking related to the resident being invited or refusing to attend any additional group activities. July 1-26, 2011 - the resident attended 5 group activities. Documentation was lacking related to the resident being			

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	invited or refusing to attend any additional group activities. An "In Room Visits, One to One & Independent Activity Record" dated July 2011 indicated the form was blank. There were no one-to-one activity records available for review for April, May, or June 2011. Interview on 7/28/11 at 10:15 A.M. with the Activity Director indicated the resident was invited to group activities but there was no documentation. She indicated the resident was being provided one-to-one activities but there was no documentation. She indicated there were pet visits and going outside activities on the activity schedule and the resident "should have been invited." The Activity Director indicated activities should be documented daily if residents attend or refuse. Review on 7/28/11 at 11:00 A.M. of a facility policy and procedure dated 6/30/06, provided by the Activity Director, identified as current, and titled "Activity Programs" indicated "...Outcomes/responses to recreation program interventions are identified in the progress notes of each resident...Examples of accommodations may include...Assisting residents, as needed, to			

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	get to and participate in desired activities (i.e., dressing, toileting, transportation)...The resident who is confined or chooses to remain in his/her room is provided with in-room recreation programs in keeping with life-long interests. Staff assist the resident with recreation programs that can be pursued independently..." 3.1-33(a)			
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure a resident received medically-related social services related to behavior monitoring, intervention and follow-up for 1 of 17 residents with behaviors in a sample of 24. (Resident #19). Findings include: On 7/26/11 at 9:10 A.M. during an initial tour with LPN #3, Resident #19 was identified as being "non-compliant and resistive to care."	F0250	F 250 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #19's physician was notified of her behavior. New orders were given. Resident #19's monthly behavior monitoring log to be reviewed weekly to determine effectiveness of interventions. A Care Plan with family and physician will be scheduled to determine appropriateness of interventions and alternate interventions. The Activity department to be included to target any interests. Social Services to review Resident #19's	08/31/2011

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	On 7/27/11 at 12:25 P.M., Resident #19 was observed sitting in a wheelchair in the restorative dining room. The resident was crying and repeatedly verbalizing "I'm gonna." Staff asked the resident "What's wrong?" The resident continued to cry and did not respond. On 7/27/11 at 12:31 P.M., Resident 19's lunch tray was served. The resident continued to cry. Staff attempted to feed the resident and again asked "What's wrong?" The resident continued to cry and did not respond. On 7/27/11 at 12:40 P.M., Resident 19 was observed being fed by staff. The resident continued to cry. Staff asked "What's the matter?" Resident 19 continued to cry and did not respond. On 7/28/11 at 7:50 A.M., Resident #19 was observed in a wheelchair in the restorative dining room with a family member. The resident was crying and the family member was attempting to soothe the resident. On 7/28/11 at 8:02 A.M., Resident #19's breakfast tray was served. The resident continued to cry. The family member attempted to soothe the resident but she continued to cry.		chart weekly until compliance has been met and then a minimum of once monthly to ensure the behavior monitoring log is complete with appropriate interventions. Social Services to meet with nursing staff to educate on appropriate current interventions for current behaviors and then as necessary based on any changes with behaviors/interventions with resident #19. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Social Services to conduct an audit of residents with a monthly behavior monitoring log to ensure proper completion of log and appropriateness of interventions to ensure residents receive medically-related social services related to behavior monitoring, intervention and follow-up. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Staff to be re-educated on the policy for Residents Exhibiting Challenging Behaviors. Social Services to review residents with ongoing behaviors during IDT meetings 3 X weekly to discuss completion of logs and appropriateness of interventions. Staff to be re-educated on behavior interventions for residents who exhibit challenging behaviors.	

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	Resident #19's clinical record was reviewed on 7/27/11 at 9:35 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, anxiety state, depressive disorder, and cerebrovascular accident (stroke). A Minimum Data Set (MDS) quarterly assessment dated 6/7/11 indicated the resident was severely impaired in cognitive decision-making skills, had minimal depression, and had no behaviors. A physician's orders recapitulation dated July 2011 indicated "...Ativan (an antianxiety medication) (Lorazepam) 0.5 mg (milligram) tablet. Give PO (by mouth) daily...Ativan (Lorazepam) 1 mg. Give PO every HS (bedtime) anxiety..." Documentation was lacking related to the resident receiving an antidepressant or an antipsychotic medication. A "Monthly Behavior Monitoring Flowsheet" dated July 1-26, 2011 indicated "...Repetitive Verbalization..." This behavior occurred on the day and/or evening shifts 25 of the 26 days monitored. The interventions for the behavior were redirection, 1:1, activity, reassurance, take for a ride, family visits. The interventions were unsuccessful 22		Re-education will consist of current behavior interventions, new admissions who exhibit challenging behaviors and as necessary based on changes with behaviors/interventions. Social Services to monitor monthly behavior logs, weekly to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. Social Services to audit behavior monitoring logs weekly to ensure ongoing compliance. Findings to be reported to the Performance Improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance. Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.	

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	times attempted. Further review indicated documentation was lacking related to the resident's crying episodes. A resident care plan dated 4/18/11 and updated 7/18/11 indicated "...Repetitive yelling - cries at times...Approach...1:1 Reassure. Hold her hand. Do not yell at her...Take for a ride...Massage hands c (with) lotion...Ask husband, sister, brother-in-law to visit, attend activity c (with) her...Ask chaplain, clergy, to pray c (with) her...Monitor Ativan use and side effects..." A nurses' notes dated 6/15/11 (no time) indicated "L.E. (late entry) for 6/14/11...Pt (patient) stating "I got it" repeatedly. Crying. Unable to explain to staff...Pt taking anxiety med (medication) ea. (each) AM (morning) c (with) no relief. Faxed physician c (with) request for change (indicated by triangle)..." A physician's order dated 6/21/11 indicated the resident had been started on Seroquel (an antipsychotic medication). A nurses' notes dated 6/21/11 at 10:00 A.M. indicated "...pt has had decreased (indicated by arrow) crying and calling out since on Seroquel..." A social service note dated 6/22/11 at			

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	10:00 A.M. indicated "Conversation c (with) daughter about resident. She states Seroquel needs to be d/c (discontinued) as resident on in past and it made her combative. Nursing made aware. Med (medication) records per daughter request to try to get psych (psychiatric) records from (name of facility) (name of city). Daughter wants resident on antipsychotic she was on there..." The Seroquel was discontinued on 6/23/11. Nurses' notes indicated: 6/24/11 at 10:30 A.M. "...Crying this AM c (with) family in room..." 6/29/11 at 4:00 P.M. "...very tearful this shift..." 7/12/11 at 2:30 P.M. "...res (resident) tearful when assessed by nurse..." 7/15/11 at 1:30 P.M. "...repetitive verbalization c (with) crying..." 7/26/11 at 1:00 P.M. "...crying, continual movement..." Interview on 7/27/11 at 10:10 A.M. with the Social Services Director indicated "we were waiting for the paperwork from the			

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	other facility. We were having trouble getting it." She indicated "the daughter wouldn't let us put her back on the Seroquel." The Social Services Director indicated the physician had not been made aware of the resident's crying. Review on 7/29/11 at 8:10 A.M. of a facility policy and procedure dated 6/30/06, provided by the Director of Nursing, identified as current, and titled "Resident Exhibiting Challenging Behaviors" indicated "...Notify the physician of behavior symptoms exhibited...Record the behavior(s) exhibited, interventions tried but unsuccessful, and/or successful interventions used on behavior monitoring log or similar tracking device..." 3.1-34(a)			
F0253 SS=C	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the	F0253	F 253	08/31/2011

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	facility failed to ensure the common shower room floors were clean and free of stains. This impacted 4 of 4 common shower rooms and had the potential to effect all 136 Residents. Findings include: During the Environmental tour of the facility with the Supervisor of Maintenance and the Housekeeping Supervisor, on 7/28/11 at 9:00 A.M., the follow observations were made: Birchwood wing: The common shower room, on the north side of the hall, had black stain around the shower area at the base of the walls. The common shower room, on the south side of the hall, had a wheelchair scale sitting on the tile floor. The tile floor had rust stains around the base of the scale and debris. Cedarwood wing: The common shower room, on the north side of the hall, had black stain around the shower area at the base of the walls. The common shower room, on the south side of the hall, had a wheelchair scale		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Birchwood wing: The common shower room, on the north side of the hall - the black stain around the shower area at the base of the walls has been cleaned The common shower room on the south side of the hall, had a wheelchair scale sitting on the tile floor. The rust stains around the base of the scales has been cleaned. Cedarwood wing: The common shower room on the north side of the hall – the black stain around the shower area at the base of the walls has been cleaned. The common shower room on the south side of the hall had a wheelchair scale sitting on the tile floor. The tile floor had rust stains around the base for the scale and debris. This has been cleaned. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. The Housekeeping Director will conduct a Quality Control Inspection of the shower rooms.	

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	sitting on the tile floor. The tile floor had rust stains around the base of the scale and debris. During an interview with the Supervisor of Housekeeping, on 7/28/11 at 9:45 A.M., he indicated a stronger cleaner was needed for the shower areas to remove the black stains and the wheelchair scales need to be moved and the floor cleaned. 3.1-18(a)		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Housekeeping staff to be re-educated on the process of deep cleaning shower rooms. Shower rooms will be deep cleaned/scrubbed weekly. The Housekeeping Director will do a Quality Control Inspectiion on the shower rooms the day they are scheduled for deep cleans as well as two other times per week. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. Housekeeping Director to conduct Quality Control Inspections on the shower rooms 3 X per week to ensure ongoing compliance. Audit findings to be reported to the Performance Improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance. Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow a physician's order for a pressure pad alarm to be placed under 1 resident while in bed. This deficiency impacted 1 of 8 residents reviewed who utilized personal alarm devices, in a sample of 24 residents. [Resident #2] Findings include: In an interview during the initial orientation tour on 7/26/11 at 9:05 A.M., R.N. #1 indicated Resident #2 had experienced a couple of recent falls. The resident was able to undo a clip alarm and was changed to a pressure pad alarm. The clinical record for Resident #2 was reviewed on 7/26/11 at 1:32 P.M. Diagnoses included, but were not limited to, dementia, anxiety, frequent falls, and history of a fractured hip with a surgical repair. On 7/13/11, the attending physician gave an order to discontinue the personal alarm, and "may have pressure alarms--chair and bed at all times."	F0282	F 282 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #2 has a pressure pad alarm in place per physician's orders. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. An audit has been conducted for residents with physician orders related to fall monitoring devices to ensure devices are in place as ordered. No issues were identified via this audit. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Nursing staff to be re-educated on following physician orders related to fall monitoring devices. Nurse management to randomly monitor (3 X weekly) residents who have fall monitoring devices to ensure physician orders are being followed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. Nurse management to randomly monitor (3 X weekly) residents who have fall monitoring devices to ensure	08/31/2011

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	155243	A. BUILDING 00 B. WING	08/01/2011

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	On 7/26/11 at 2:13 P.M., the resident was observed laying in bed. A pressure pad was observed in his wheelchair seat, and was connected to the alarm unit which was placed on the back of the wheelchair. The wheelchair was parked next to, and at the foot of, the resident's bed. There was no other pressure pad under the resident, and no other alarm unit observed in the area of the resident's bed. On 7/27/11 at 1:30 and 3:10 P.M., the resident was observed laying in bed. The pressure pad was again observed in the wheelchair seat and connected to the alarm unit on the back of the wheelchair. No pressure pad or other alarm was observed on the resident's bed. 3.1-35(g)(2)		physician orders are being followed. Audit findings to be reported to the Performance Improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance. Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.	
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure interventions were in place and revised to prevent falls related to alarms for 1 of 7	F0323	F 323 What corrective action(s) will be accomplished for those residents found to have been affected by the	08/31/2011

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	residents with falls in a sample of 24. (Resident #22). Findings include: On 7/26/11 at 9:10 A.M., during an initial tour with LPN #3, Resident #22 was identified as being ambulatory with a wheelchair, having bed and chair alarms, and having had a fall within the previous two weeks. On 7/27/11 at 11:07 A.M., Resident #22 was observed lying in bed in his room. There was a pressure alarm in place on the bed. Resident #22's clinical record was reviewed on 7/28/11 at 10:35 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, paralysis agitans (a degenerative nerve disorder), muscle/ligament disorder, and Parkinson's disease. A Minimum Data Set (MDS) quarterly assessment dated 4/30/11 indicated the resident was moderately impaired in cognitive decision-making skills, was independent in transfers, toilet use, required limited one-person physical assistance for ambulation in room, locomotion on and off unit, balance was		deficient practice. Resident #22 no longer resides in the facility. Audit to be conducted of residents who have had a fall within the last 30 days (July 10) to ensure interventions are appropriate. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Staff to be re-educated on appropriate interventions for falls.. Nurse management to audit residents who have a fall to ensure that post fall interventions are appropriate. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. Nurse management to review documentation for residents who have had falls 3 X weekly to ensure post fall interventions are appropriate. Audit findings to be reported to the Performance Improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance.	

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	not steady but could stabilize without human assistance, and had one fall with injury since admission. A "Nursing Assessment/Partial" form dated 4/26/11 indicated "...Transfers...Supervision (indicated by checkmark)...Toilet Use...Supervision (indicated by checkmark)...Ambulation/Mobility...Limited Assist...W/C (wheelchair) for long distance...Risk Assessment-Falls...Safety Awareness...Occasionally needs reminders (indicated by checkmark)...Functional...Shuffled gait/balance problems (indicated by checkmark)...Significant history...Recent increased/decreased mobility..." Further review indicated a score of 10, moderate risk for falls. A resident care plan dated 2/26/10 and updated on 8/31/10 and 4/25/11 indicated "...Risk for fall dx (diagnosis) Parkinson's...Approach...(1) Keep call light in reach and remind resident to use for assistance. (2) Therapy to strengthen. (3) Keep floor free of clutter. (4) Answer call light in timely manner. (5) Offer toileting before & p (after) meals..." A physician's orders recapitulation dated July 2011 indicated "...6/28/11 Bed alarms to notify staff of unassisted transfers..."		Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.	

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Nurses' notes indicated:

4/21/11 at 12:00 P.M. "...Pt (patient) c (with) increased (indicated by arrow) unsteady ness (sic)..."

4/24/11 at 9:00 P.M. "...Gait unsteady this shift. Personal alarm placed on pt (patient)..."

4/25/11 at 2:00 P.M. "...Unsteady on feet @ X's (times)..."

A social service note dated 4/29/11 at 1:00 P.M. indicated "...Wife cared for resident at home as long as she could twice but he began to fall multiple times..."

Nurses' notes indicated:

5/19/11 at 2:00 P.M. "...A & O (alert and oriented) c (with) some forgetfulness...Gait becomes fast/shuffling @ X's, needs reminders to slow down..."

6/10/11 at (no time) "...Transfers & ADLs (activities of daily living) independent. Ambulates slowly behind W/C (wheelchair)..."

6/16/11 at 10:00 A.M. "...Transfers self....Walks in room independently..."

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	6/28/11 at 2:35 A.M. "Res (resident) had has a fall. Was ambulating to restroom and went down on to his knees. Was witnessed by (staff name) LPN happening in hallway...Res gait has been a bit unsteady. Abrasion to (R) (right) and (L) (left) knees..." Documentation was lacking related to an alarm being in place and functioning. 6/29/11 (no time) "LE. (late entry) for 6/28/11 6-2 P.M. "Pt very unsteady..." A "Post Fall Evaluation" dated 6/28/11 indicated "..Res ambulating to bathroom and fell to knees...intervention in place at time of fall...call bell in place...unassisted ambulation...unsteady gait...history of fall(s)...immediate interventions taken to protect the resident: low bed and bed alarm..." A resident care plan dated 2/26/10 and updated 6/28/11 indicated "...low bed, bed alarm..." A nurses' note dated 7/3/11 at 10:40 A.M. indicated "...Pt (patient) had unwitnessed fall. Found sitting on floor - leaning against hamper. States he fell on buttocks...Bed alarm in place - pt (patient) knows how to reset. States he was trying to dress..."			

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	A "Post Fall Evaluation" dated 7/3/11 indicated "..Pt out of (indicated by arrow) bed to dress self. Confused. Trying to put pajamas on @ 10:40 A.M. Lost balance fell on buttocks in sitting position...intervention in place at time of fall...alarm...low bed...Location of resident prior to the fall...bed...unassisted ambulation...unsteady gait...history of fall(s)...change in cond. (condition)...immediate interventions taken to protect the resident: personal alarm, low bed..." A resident care plan dated 2/26/10 and updated 7/3/11 indicated "...personal alarm..." Documentation was lacking to address the resident resetting or turning off the bed alarm. Nurses' notes indicated: 7/5/11 at 2:10 P.M. "...Personal alarms used, pt will remove on own @ X's. Enc (encouraged) not to get up alone..." 7/8/11 at 1:40 P.M. "...Stable on feet c (with) W/C in front of him. Cont. (continues) to move slowly. Bed alarms in place although pt aware of how to turn them off..." 7/10/11 at 2:00 P.M. "...Pt needs reminders not to transfer self.			

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	Personal/bed alarm used. Unsteady on feet..." 7/11/11 at 4:40 P.M. "...Ambulating in room behind W/C..." 7/13/11 at 4:30 P.M. "...Nurse made aware that resident fell on 7/12/11. Res got himself back up and went to bed. Roommate (sic) made nurse aware. Pt states he cannot remember falling and getting back up..." A "Post Fall Evaluation" dated 712/11 indicated "..Res fell and got himself back up. Res doesn't remember falling. Roommate (sic) informed nursing staff of situation...intervention in place at time of fall...alarm...low bed...Location of resident prior to the fall...standing/walking...unsteady gait...immediate interventions taken to protect the resident: bed alarm/personal alarm...Summary of Interdisciplinary Team: pressure/bed chair alarms at all times except when ambulating..." A resident care plan dated 2/26/10 and updated 7/3/11 indicated "...pressure/bed chair alarm at all times except when ambulating..." Documentation was lacking to address the resident resetting or turning off the bed and personal alarms.			

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	A "Weekly - Physical Therapy Progress Note" dated 7/13/11 indicated "...safety awareness...poor...impairments limiting progress and/or barriers to improvement: balance, gait, safety strengthening...fall risk..." Interview on 7/28/11 at 12:40 P.M. with the unit manager indicated documentation was unavailable for review related to the resident being toileted before and after meals. She indicated the alarm had been turned off before the 7/3/11 and 7/12/11 fall and had not sounded. She indicated interventions had not been implemented to address the resident resetting or turning off the alarms stating "I should have been proactive instead of reactive." Review on 8/1/11 at 9:35 A.M. of a facility policy and procedure dated 4/28/11, provided by the Director of Nursing, identified as current, and titled "Accidents and Supervision to Prevent Accidents" indicated "The center provides an environment that is free from accident hazards over which the center has control and provides supervision and assistive devices to each patient to prevent avoidable accidents. This includes systems and processes designed to:...Implement interventions to reduce hazard(s) and risk(s)...Monitor for effectiveness and modify approaches			

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	when necessary..." 3.1-45(a)			
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to quantitatively and objectively document specific targeted behaviors to support the use of psychoactive medications; and/or failed to attempt a G.D.R. [Gradual Dose Reduction] of psychotropic medications, or have a physician provide a detailed discussion and description of the rationale for why an attempt would be clinically	F0329	F 329 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #2 received a gradual dose reduction. Order for Lorazepam was reduced to .25 mg q am x 2 weeks then dc. Resident #103 received a gradual dose reduction. Order for Seroquil was reduced from 25 mg to 12.5 mg. How other residents having the potential to be affected	08/31/2011

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	contraindicated. This deficiency impacted 2 of 10 residents who were receiving psychotropic medications, in a sample of 24 residents. [Residents #2 and #103] Findings include: 1. In an interview during the initial orientation tour on 7/26/11 at 9:05 A.M., R.N. #1 indicated Resident #2 "fights with staff" during morning care because he didn't like to get up. The clinical record for Resident #2 was reviewed on 7/26/11 at 1:32 P.M. Diagnoses included, but were not limited to, dementia, depression with delusions, and anxiety. On 12/18/09, the physician ordered Remeron [an antidepressant medication] 30 mg. [milligrams] one daily at bedtime for "depression and appetite enhancer." The "Resident Care System Weight History" form indicated the resident had experienced a gradual weight loss from 139 pounds in July, 2010 to 127 pounds in July, 2011. On 1/6/10, the physician ordered Celexa [an antidepressant medication] 20 mg. one daily. On 1/7/10, the physician ordered Ativan		by the same deficient practice will be identified and what corrective action(s) will be taken. Audit to be conducted for residents receiving psychotropic medications to ensure the facility has quantitatively and objectively documented specific targeted behaviors to support the use of psychoactive medications, and/or attempted a GDR of psychotropic medications, or have a physician provide a detailed discussion and description of the rationale for why an attempt would be clinically contraindicated. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Staff to be re-educated regarding Gradual Dose Reduction for residents receiving psychotropic medications. Social Services to randomly audit 5 residents 3 times weekly to ensure gradual dose reductions are attempted. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. Social Services and/or Nurse Management to randomly audit 5 residents 3 times weekly until sustained compliance, then to be reviewed by Social Services monthly. Audit findings to be reported to the Performance Improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance.	

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	[an anti-anxiety medication] 0.5 mg. one daily in the morning for "anxiety." On 5/20/10, the physician ordered Seroquel [an anti-psychotic medication] 50 mg. one in the morning and Seroquel 100 mg. one at bedtime for "psychosis with delusional and aggressive behavior." The March, 2010 "Monthly Behavior Monitoring Flowsheet" form listed target behaviors of "rummages" and "withdraws." The form indicated the resident had no ["0"] episodes of "withdraws" behavior. There was no target behavior listed to monitor for "delusions." The April, 2010 "Monthly Behavior Monitoring Flowsheet" form listed target behaviors of "combative with care," "withdraws," and "rummages." The form indicated the resident had experienced 1 episode of "combative with care" behavior daily on the Day shift for 24 of 30 days, and 1 episode daily on the Evening shift for 13 of 30 days. There were 4 episodes of withdrawing on the Day shift, and 1 episode on the Evening shift. There was no target behavior listed to monitor for "delusions." The May, 2010 "Monthly Behavior Monitoring Flowsheet" form listed target		Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.	

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	behaviors of "combative with transfers and care," "rummages," "withdraws," and "restless--gets up unassisted." The form indicated the resident had experienced 1 episode of "combative with care" behavior daily on the Day shift for 22 of 31 days, and 1 episode daily on the Evening shift for 8 of 31 days. There was 1 episode of withdrawing on the Evening shift. There was no target behavior listed to monitor for "delusions." The "Comments/Observations/Conclusions" section of the March, 2011 "Monthly Behavior Summary / Psychoactive Gradual Dose Reduction Review" form indicated "3/30/11--Resident continues to be combative daily with staff when they get him up. Staff does try to get resident up as late as possible. Once resident is up, he is okay. Resident interacts well with writer, family, staff. He likes to 'read' daily paper, books. He continues to rummage daily. He will rummage through cares, things in busy box. He is out of room daily. Likes 1:1.... Gets along with roommate." The April 2011 "Monthly Behavior Summary" form indicated "4/29/11... He remains combative when staff get him up. After that he settles down...."			

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	The June, 2011 "Monthly Behavior Summary" form indicated "6/30/11- -Resident combative with care daily. Does not like to be gotten up. Once he is up he is usually okay...." There was no information on the summaries related to a G.D.R. attempt, or episodes of delusions. A Care Plan entry, with an original start date of 12/27/10, addressed a problem of "Combative with staff during care." One of the interventions was listed as "Do not wake him too early, he is not an early riser." In an interview on 7/27/11 at 8:51 A.M., C.N.A. #2 indicated she came in at 6:00 A.M., and gets Resident #2 up at 6:30 A.M. She stated "He doesn't like to get up." The C.N.A. indicated she did not know why the resident did not like to get up in the morning. She also indicated she got the resident up at 6:30 A.M. because that was the time that was listed on her "get-up" assignment sheet, and she was just doing what she was told. In an interview on 7/27/11 at 2:00 P.M., the Director of Nursing indicated staff use to get Resident #2 up at 5:00 A.M., but changed it to 6:30 A.M. because he was usually starting to rouse by that time and			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANS CARE AND REHAB-GREATER LAFAYETTE	300 WINDY HILL DRIVE LAFAYETTE, IN47905

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	attempting to crawl out of bed. She indicated she knew he had worked a night shift during his lifetime occupation as a factory worker. In an interview on 7/27/11 at 2:20 P.M., the Social Service Director indicated she believed his behaviors had decreased. She indicated a G.D.R. had not been attempted for any of the psychotropic medications. She indicated the facility did have a consultant psychiatrist, and had recently obtained the services of a consultant psychiatric Nurse Practitioner. However, Resident #2 had not been referred to either one. A physician's progress note, dated 6/21/11, indicated "Resident exempt from medication reduction due to continued daily combative behaviors toward staff." There was no other documentation from the physician or facility staff that provided a justification for the continued use of the medication, explored possible adjustment of dosages or switch to a different medication in order to obtain effective results. 2. Record review for Resident #103 was completed on 7/28/11 at 12:15 P.M. The resident's diagnoses included, but were not limited to, dementia, failure to thrive, and anemia.			

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	The physician recap indicated that the resident was currently on Remeron (an antidepressant) as an appetite stimulant since 6/20/09. The resident's weight was 119 pounds in January 2011 and for July is 109 pounds. The recap also indicated that the resident is receiving Seroquel 25 mg (antipsychotic) every night. The resident has been on Seroquel since 1/12/10. A request for the most recent GDR (gradual dose reduction) was given to the DON. She provided the following documents on 7/28/11 at 1:45 P.M. A document titled ' Note To Attending Physician/Prescriber' dated 9/17/10, indicated, "...Please consider d/c(discontinuing) of Remeron d/t (due to) not sufficiently effective to warrant continued use..." The doctor marked with a check a box that indicated disagree and did not give any clinical rational as to the continuation of medication. The Medication Regimen review provided by the DON, dated 6/18/10, indicated that "...the resident has been receiving Seroquel 25 mg hs since 1/12/10. Please evaluate the current dose and consider a gradual taper to ensure resident is using the lowest possible effective dose. CLINICAL RATIONALE MUST BE DOCUMENTED PER CMS IF			

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	REDUCTION NOT ATTEMPTED..." The physician marked a check by a box indicating"...Patient has had good response to treatment and requires this dose for condition stability. Dose reduction is contraindicated because benefits outweigh risks at this time, a reduction is likely to impair the resident's function and/or cause psychiatric instability, and patient is tolerating current dose sufficiently..." In an interview with DON 7/28/11 at 1:45 P.M. it was asked if these were the most current reviews of these two medications for the resident, she indicated that these were all she could find. On 7/29/11 at 8:10 A.M., the Director of Nursing provided a policy/procedure titled "Antipsychotic Medications." The policy/procedure included, but was not limited to, the following information: "Policy: Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. Compliance Guidelines:... 2. Antipsychotic medications are used for			

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	organic mental syndromes with associated psychosis and/or distressing behaviors only: a. which have been quantitatively and objectively documented... b. which are persistent; c. which are not caused by preventable reasons; d. which are causing the resident to 1) present a danger to himself or to others, or 2) continuously scream, yell, or pace if these specific behaviors cause an impairment in functional capacity... 3) experience psychotic symptoms not exhibited as dangerous... but which cause the resident distress or impairment in functional capacity.... 4. Within the first year in which a resident is admitted on an antipsychotic medication or after the center has initiated an antipsychotic medication, the center attempts a gradual dose reduction (GDR) in two separate quarter (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. 5. For an individual who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: a.) the resident's target symptoms returned or worsened after the most recent attempt at a GDR.... b.) the			

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	physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.... 6. ... the GDR may be considered contraindicated if... c.) the resident's physician provides a justification why the continued use of the drug and the dose of the drug are clinically appropriate. This justification should include: 1) a diagnosis, but not simply a diagnostic label or code, but the description of symptoms, 2) a discussion of the differential psychiatric and medical diagnosis... 3) a description of the justification for the choice of a particular treatment... 4) a discussion of why the present dose is necessary to manage the symptoms of the resident...." 3.1-48(b)(2)			

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F0356 SS=C	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview, the facility failed to post the daily Nurse staffing hours for three days. The impacted 2 of 2 nursing units for 3 of 5 days. Findings include:	F0356	F 356 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility will post the following information on a daily basis: Facility Name, The current date, the total number and the actual hours worked by the following categories of licensed	08/31/2011

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	On 7/25/11 at 12:55 P.M., the Nursing Staffing hours posted were observed. There were no specific hours listed but only checkmarks. During an interview with the Administrator on 7/25/11 at 1:00 P.M., she indicated the Daily Nurse Staffing hours were not correct with only checkmarks. The posting of the Daily Nurse Staffing hours was removed. The Daily Nurse Staffing hours were not posted on 7/26/11 at 9:00 A. M or on 7/27/11 at 1:00 P.M. During an interview with the Administrator, on 7/29/11 at 8:30 A.M., she indicated the Daily Nurse Staffing hours were still not the way they should be but it was getting closer. The hours were posted on 7/28/11 at 1:30 P.M. 3.1-13(i)(4)		and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses or licensed vocational nursesand certified nurses aides, and Resident census. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Staff responsible (nurse manager on duty) for posting staffing information will be re-educated on the requirements for the posting. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. Facility Administration to audit the posting 3 X weekly to ensure the staffing is posited appropriately. Audit findings to be reported to the Performance Improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance. Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.	

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure appropriate guidelines were implemented to prevent the potential for spread of infection related to co horting residents	F0441	F 441 What corrective action(s) will be accomplished for those residents found to have been affected by the	08/31/2011

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	with infections for 1 of 4 residents in isolation in a sample of 24. (Residents #25, #36). Findings include: On 7/26/11 at 9:10 A.M. during an initial tour with LPN #3, Resident #36 was identified as having a foley catheter, a colostomy and a Stage II (partial thickness loss of dermis) pressure ulcer on his sacrum. There was a foley catheter collection bag hanging at the bedside. On 7/26/11 at 9:10 A.M., during an initial tour with LPN #3, Resident #25 (Resident #36's roommate) was identified as being in contact isolation for MRSA (methicillin resistant staphylococcus aureus) (a bacteria) in a wound on his left clavicle area and clostridium difficile (a bacteria). There was a plastic isolation drawers sitting outside the residents' room. Resident #36's clinical record was reviewed on 7/27/11 at 8:32 A.M. A physician's orders recapitulation dated July 2011 indicated "...Sacral wound care...Foley cath (catheter) care every shift...change colostomy appliance every 3 days and PRN (as needed)..." Resident #25's clinical record was reviewed on 7/26/11 at 1:25 P.M. A		deficient practice. Residents #25 and #36 were moved to appropriate rooms to prevent the potential for spread of infection related to cohorting residents with infections. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Nurse Management completed an audit of current facility residents to validate that they are cohort appropriately in accordance with facility protocol. No issues were identified upon completion of the audit. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Staff to be re-educated on placing new admissions, hospital returns, and residents with change of condition in appropriate rooms to avoid the potential for spread of infection related to cohorting residents with infections. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.	

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	physician's orders recapitulation dated July 2011 indicated "...contact isolation C-diff (clostridium difficile)...oxacillin (an antibiotic) 2 GM (grams) IVPB (intravenous piggyback) every 6 hours clavicel (sic) wound..." Interview on 7/27/11 at 10:40 A.M. with the Unit Manager #4 indicated Resident #25 had MRSA and C-Diff. She indicated Resident #36 was placed in the room "because (Resident #36) doesn't use the bathroom." She indicated Resident #36 would be at risk for infection and should not have been placed in the same room. Review on 7/27/11 at 11:15 A.M. of a facility policy and procedure dated 10/31/09, provided by the Director of Nursing, identified as current, and titled "Infection Control and Prevention Program" indicated "...Residents infected with multiple drug resistant organisms (MDRO) may be placed in a room with other residents with MDRO infections or residents at low risk for infection (e.g., residents without wounds, IVs, indwelling catheters, etc.)..." 3.1-18(j)		Nurse management to audit infection control log 3 X weekly to ensure residents are in proper rooms to avoid the potential for spread of infection related to cohorting residents with infections. Audit findings to be reported to the Performance Improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance. Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.	

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F0465 SS=A	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based observation and interview, the facility failed to ensure non-medication items were not stored in the medication refrigerator in the medication storage room on Birchwood. This impacted 1 of 2 medication refrigerators and the potential to affect 71 Residents. Findings include: During the Environmental tour, on 7/28/11 at 10:00 A.M., the refrigerator in the Birchwood medication room had a small, unlabeled plastic bag with cooked chicken and asparagus stored in with the refrigerated medications. During an interview with LPN #5, on 7/28/11 at 10: 05 A.M., she indicated the chicken and asparagus should not be in the medication refrigerator. A Policy for "Storage of Medications" received from the Director of Nursing on 7/29/11 at 10 30 A.M., dated 2/23/11, indicated the following: "20. Keep refrigerated medications in closed and labeled containers, with	F0465	F 465Non Medication items were removed from the medication refrigerator in the Birchwood medication room.Medication refrigerators were checked to ensure non medication items were not stored in medication refrigerators. No other issues were identified.Staff have been re-educated on Storage of Medications.Nurse Management to randomly monitor (3 X weekly) medication refrigerators to ensure ongoing compliance.Findings to be reported to the Performance Improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance. Audit results and system components will be reviewed by the Performance Improvement committee with subsequent plans of correction developed and implemented as deemed necessary.	08/31/2011

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	internal and eternal medications separated and separate from fruit juices, applesauce, and other foods used in administering medications. Other foods such as employee lunches, activity department refreshments are not stored in this refrigerator." 3.1-19(f)			